UTILIZATION REVIEW REPORT

INTRODUCTION

Under the provisions of the Multipurpose Senior Services Program's (MSSP) Home- and Community-Based Services (HCBS) Waiver and the State Medicaid Plan, the program is required to establish and maintain a system of Utilization Review (UR). The authority to conduct these reviews is found in the following sources:

Federal – Title XIX, Social Security Act, Section 1915 I; 42 Code of Federal Regulations (CFR), Section 456; Federal Home- and Community-Based Services Waiver.

State – Welfare and Institutions (W&I) Code, Section 14170; Title 22 California Code of Regulations, Title XXII, Section 51346; Interagency Agreement #01-15976 between Department of Health Care Services (DHCS) and California Department of Aging (CDA) and CDA policies.

The CDA conducts collaborative and independent URs to monitor the program at the site level for compliance with the Waiver, the Interagency Agreement (IA) between CDA and DHCS, and CDA MSSP policies. Currently, each site is scheduled to be reviewed every other year. The objectives of the CDA UR process are to:

1. Verify the medical necessity of services provided to eligible MSSP clients funded by the HCBS Waiver.
2. Ensure that available resources and services are being used efficiently and effectively.
3. Identify problem areas and to provide technical assistance (TA) as needed.
4. Initiate corrective action(s), if warranted.

The process followed by the CDA UR team involves a review of pertinent documentation, procedures and processes; consultation and discussion with staff; and a home visit to a client. The specific areas addressed by this report are:

1. NECESSITY OF SERVICES: Client Eligibility and Level of Care (LOC).
2. CLIENT ENROLLMENT, RIGHTS, AND INFORMATION: Application, Client Enrollment /Termination Information Form (CETIF), Notification of Rights, Authorization for Use and Disclosure of Protected Health Information Form (AUDPHI), Institutionalization Form (IF).
3. APPROPRIATENESS OF SERVICES: Initial Health Assessment (IHA), Initial Psychosocial Assessment, Reassessment (IPSA), Care Plan, Assessing and Documenting Client Risk, Progress Notes, and Case Record.

4. AUTHORIZATION AND UTILIZATION OF SERVICES: Service Planning and Utilization Summary (SPUS), Tracking Cost Effectiveness, and Vendor Agreement Review.

5. QUALITY ASSURANCE ACTIVITIES: Peer/Internal Review, Client Satisfaction Survey and Home Visit.

METHODOLOGY

Review Date:	April 26, 2010 through April 29, 2010
Review Site:	Multipurpose Senior Services Program P. O. Box 42 Modesto, California 95353-0042
Record Review:	Fifteen case records, five of which were terminated. Ten vendor files.
Review Period:	September 2008 through October 2009
CDA-MSSP Review Team:	Vicki Cabassi, Nurse Evaluator II Taffy Warner, Program Analyst II Susan Rodrigues, Program Analyst II
Scheduled Conferences:	Entrance: April 26, 2010 Exit: April 29, 2010
Conference Participants:	Stephanie Navarette, Site Director Sou Yang, Social Worker Care Manager (SWCM) Yvette Benevidez, SWCM Fred Gack, Nurse Care Manager (NCM) Beverly Eldridge, NCM Pat Chladek, Administrative Support Kristi Garcia, Fiscal

DEFINITION OF TERMS

1. Findings:
   - Conclusions reached after the UR. Documents site practices during the review period. Compares what exists at the site with what is required.

2. Recommendations:
   - Actions necessary to correct existing conditions or improve operations and practices. The recommendations indicated in this report are requirements not suggestions.

3. Technical Assistance:
   - Documents information provided to site staff during UR. Includes consultation on specific client cases, printed information, online resources, policy references, etc. TA may also document subsequent research and responses provided to site staff following the UR.

4. Corrective Action:
   - Remediates problems found in site practices and ensures compliance to MSSP policies including the federal Waiver and the current Contract. A Corrective Action Plan (CAP) includes but is not limited to the following:

     ➢ Revision of the site's existing procedures and practices or development of new ones. The site shall submit written documentation describing these changes.

     ➢ Training of site staff necessary to implement the required CAP. Training documentation to be submitted to CDA may include, but is not limited to, the following:
       - o Schedule of in-service sessions and dates;
       - o Sign-up sheet or roster of session attendees;
       - o Agenda or syllabi of sessions (topics covered);
       - o Name of person(s) conducting the sessions;
       - o Session hand-outs; and
       - o Synopses of session results including specific problem areas addressed.

     ➢ Periodic submittals to CDA, which may include examples of redacted case record documents, such as care plans, assessment forms, progress notes, etc., produced following the required training and remediation.

CORRECTIVE ACTION PLAN

A CAP is required as specified in the following UR Findings. A CAP is required to ensure compliance with the listed findings and recommendations. Please submit to CDA within 30 days. CDA reviewers may attend scheduled in-service training sessions developed in conjunction with the CAP without notice.

I. NECESSITY OF SERVICES

The objective of the MSSP is to avoid, delay, or remedy the inappropriate placement of persons in nursing facilities, while fostering independent living in the community. At a cost lower than nursing facility placement, MSSP provides services to eligible clients and their families to enable clients to remain in or return to their homes. Case record documentation must support the client's need for these services.

Reference: MSSP Site Manual

I. A. Client Eligibility

Eligibility for the program is addressed initially at screening and confirmed throughout participation in the program. MSSP eligibility criteria include all of the following:

- Age 65 or older;
- Residence in the catchment area;
- Receiving Medi-Cal under an appropriate code;
- Certifiable for placement in a nursing facility (NF) (refer to the LOC section of this report for criteria requirements);
- Ability to be served within the cost limitations of MSSP and
- Appropriate for care management services.

Reference: MSSP Site Manual

Findings:

All fifteen client records reviewed met MSSP eligibility criteria.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

I. B. Level of Care

The LOC determination is a clinical judgment made by the NCM. The LOC is a timely analysis of information gathered to determine and verify that the client is certifiable for placement in an Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF). The body of the client's case record must support the LOC determination.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

Four of fifteen client records (#XXXX, #XXXX, #XXXX, and #XXXX) did not completely describe the client's functional limitations ensuring eligibility. Information was found elsewhere in the records that did establish eligibility for MSSP.

For example, the XXXX XXXX LOC in client record #XXXX did not address the client's cognition or ability to perform XXXX or XXXX, chores, XXXX or XXXX XXXX. The LOC also did not describe the client's XXXX needs.

Two client records (#XXXX and #XXXX) did not describe the type of assistance the client required to complete IADLs.

Client Record #XXXX contained a discrepancy between the LOC and the Functional Needs Assessment Grid (FNAG). The XXXX XXXX LOC contained documentation that the client was not able to complete XXX laundry. The FNAG contained documentation that the client did XXX own laundry.

Recommendations:

Incorporate the following TA into site policies and procedures. Conduct a training session within 60 days from the date of this report to ensure LOC documentation is followed according to program requirements. Submit to CDA the curriculum used, name of the person conducting the session, and a list of attendees.

Technical Assistance:

When completing LOCs, the NCM must focus their analysis and judgment on the following elements:

- cognition,
- level of assistance required to perform IADLs, (hands-on or stand-by),
- use of assistive devices, and
- how medical conditions affect the client's ability to function.

Review MSSP Site Manual Section 3.110.3 Application of Title 22 Criteria and 3.110.5 Completion of LOC Certification Sheet which states, "The LOC certification form must be completed to certify the LOC requirement. This validates that the client meets the eligibility criteria "certifiable for placement in a nursing facility... The client's case record must contain supporting documentation or evidence that substantiates the client's LOC.

A LOC tool with examples was provided during the exit conference.

Corrective Action:

A CAP is required.

II. CLIENT ENROLLMENT, RIGHTS AND INFORMATION

II. A. Application

The application form is the vehicle for applying for services and summarizes what a client can expect from MSSP, alternatives regarding services and the rights of program participants. The application must be completed prior to conducting the LOC determination, and a copy of the application must be provided to the client.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

The date the client received a copy of the application was missing in two client records, (#XXXX and #XXXX).

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.330 Application which states the application summarizes what the client can expect from the program, alternatives regarding services, and the rights of program participants. The application must be completed for all persons interested in participating in the MSSP. A copy of the form must be provided to the client.

Corrective Action:

As the findings do not represent a trend, a CAP is not required.

II. B. Client Enrollment/Termination Information Form

The CETIF records client demographic information. Data fields must be complete and accurate. As data is changed or updated, a new hard copy must be printed and filed chronologically in the record.

References: MSSP Site Manual and MSSP Contract.

Findings:

The enrollment date for client #XXXX was prior to the completion of the LOC. The enrollment date was XXXX, XXXX; the LOC was completed on XXXX, XXXX.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance

Review MSSP Site Manual Section 3.410 Sequence of Enrollment Activities which states an Application for participation in MSSP must be completed prior to conducting the LOC determination. Enrollment occurs after the client has completed and signed the Application and the Nurse Care Manager has completed the initial LOC certification.

Corrective Action:

As this finding does not represent a trend, a CAP is not required.

II. C. Notification of Rights

MSSP sites must inform clients and/or their designees of their right to be informed of MSSP components which are material to a client's participation (or lack of participation) in the MSSP. Program components include:

1. Processes on registering complaints, termination and appeal;

2. The safeguarding of client information (including application, care plan and termination form) through proper use of the AUDPHI Form and storage of client records;

3. Services that may be provided by MSSP as well as alternatives to participation in the program;

4. Potential outcomes of refusing offered services; and

5. Client participation in MSSP care planning and service satisfaction surveys.

Notices of Action (Termination and Change):

- State law and Medi-Cal regulations require that a Notice of Action (NOA) be sent to an applicant who is denied eligibility at point of application or to a MSSP client who has a change in service or who is terminated (for codes specified in the Site Manual) from the program. Timeframes for mailing NOAs are specified in the Site Manual. The NOA informs the applicant/client of rights to a fair hearing if they are dissatisfied with the termination action, change in services, or denial of entry into the MSSP. A copy of the NOA will be filed in the client's case record.

Client Rights/Right to State Hearing:

- Clients will be informed in writing and in a timely manner of their right to request a State Medi-Cal hearing when they indicate disagreement with any decision, which would result in a discontinuance, termination, suspension, cancellation or decrease of services under the program.

Reference: MSSP Site Manual and California Welfare and Institutions Code

Findings:

Seven of fifteen client records reviewed (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) lacked NOAs when items purchased with waiver funds were removed from the care plan.

Recommendations:

Incorporate the following TA into site policies and procedures. Conduct a training session within 60 days from the date of this report to ensure Notices of Action documentation is followed according to program requirements. Submit to CDA the curriculum used, name of the person conducting the session, and a list of attendees.

Technical Assistance

Review MSSP Site Manual Section 3.640.8 Changes to the Care Plan which states clients will participate in any discussion or plans regarding any changes to their care plan. This participation will be documented in the progress notes. Changes to the care plan must be dated and signed by the PCM. Clients must receive notices of action regarding reductions or termination of previously authorized waiver services.

The client will be sent either a copy of the care plan that has been revised to reflect the reduction or termination, or a separate letter that fully identifies and describes the action that has changed. These written notices must also include the State Hearing Notice (Appendix 5).

Corrective Action:

A CAP is required.

II. D. Authorization for Use and Disclosure of Protected Health Information Form

MSSP sites must comply with contract requirements regarding client confidentiality. Sharing and obtaining information requires specific client consent as provided in the AUDPHI. This form must:

- Address only one individual or agency;
- Be specific as to the particular information (such as diagnosis, treatment, or financial information) that is requested from/to that entity; and
- Include an expiration date which cannot exceed two years from the date of the client's signature.

References: MSSP Site Manual and MSSP Contract

Findings:

All fifteen client records lacked the CM's dated signature on the AUDPHI forms.

Two client records (#XXXX and #XXXX) did not identify the type of information that would be disclosed.

The date the AUDPHIs were completed was missing in client record #XXXX. This record also lacked an AUDPHI for the client's XXX who was present during a home visit where XXXX and the XXXX were discussed.

Client Record #XXXX contained AUDPHIs that expired in XXXX XXXX. No new AUDPHIs were completed up to the date the client was terminated from the program in XXXX XXXX.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Refer to MSSP Site Manual Section 3.510 Confidentiality which states:

"...In all cases (including family members) the client must sign a written consent to obtain or release such information (AUDPHI form, Appendix 14)."

MSSP Site Manual Section 3.520 AUDPHI Form states:

"All pertinent data will be entered on the form before the client is asked to sign. Staff will not have clients sign blank forms (e.g., with the intent of staff filling in necessary information on an "as needed" basis at a later date)."

The September 2007 Site Manual revision of Section 5.810 requires MSSP staff and client sign the AUDPHI form. The current MSSP Site Manual version of the form, Appendix 14, does not have a line for staff's signature. The form may be revised to include a line for staff's signature or staff may sign on the "witness" line.

Corrective Action:

A CAP is required.

II. E. Institutionalization Form

Information regarding a client's admissions to a hospital (in-patient and out-patient) or NF and emergency room visits are to be recorded on the IF. MSSP sites are responsible for the inclusion of the IF in the client case record. The IF provides a chronology of the client's hospitalizations and admitting diagnoses.

Reference: MSSP Site Manual

Findings:

Three client records (#XXXX, #XXXX, and #XXXX) were missing either an emergency room visit or a hospitalization on the IF as documented in progress notes.

Four client record (#XXXX, #XXXX, #XXXX, and #XXXX) contained entries that were either incomplete or incorrect as documented in progress notes.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Refer to MSSP Site Manual Section 3.1220 Institutionalization Form which states:

"Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the IF (Appendix 23)."

Corrective Action:

As findings do not represent a trend, a CAP is not required.

III. APPROPRIATENESS OF SERVICES

The criteria for Appropriateness of Services address the client's need for and ability and willingness to participate in the care management process. Both elements must be present.

- "Need for care management" is indicated when a client requires assistance to: gain access to community services (whatever the funding source); maintain or effectively utilize available services; or manage serious health conditions.

- "Ability and willingness to participate" is indicated by the client's cooperation in formulating and then carrying out the care plan. The term "client" includes a client's significant support person when the client is cognitively unable to participate independently.

It is important to confirm and document a new client's perception of why they were referred to the program, and how they characterize their situation, needs and goals. This would logically occur during either the screening or the assessment process. Differences in perceptions between the referral source, the client and the CM must be identified, acknowledged and addressed in the initial assessments.

References: MSSP Site Manual and MSSP Contract

III. A. Initial Health Assessment, Initial Psychosocial Assessment, and Reassessment

Assessment is the foundation of the care management process. Each person determined to be eligible through the MSSP intake screening process will receive face-to-face comprehensive IHA and IPSAs to determine specific problems, resources, strengths, needs and preferences and to confirm LOC.

Reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment, re-establishing eligibility as it relates to LOC and assuring that the client's needs are being met. Changes since the last assessment, as well as over a longer span of time, are particularly relevant.

Assessment instruments and forms include but are not limited to:

- IHA and IPSA
- Reassessments
- Summaries and Problem Lists
- Client's Medication List
- Client's Physicians and Other Health Professionals
- Initial Psychosocial Functioning
- CDA Approved Cognitive Screening Tool
- FNAG

References: MSSP Site Manual and MSSP Contract

Findings:

The CM's dated signature was missing on the IPSA in client record #XXXX.

The medication assessment section was blank on the IHA in client record #XXXX.

Recommendations:

Incorporate the following TA into site policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.620 Assessment/Initial Assessments which states:

"Initial assessments will be reviewed for completeness of functional information and pertinent medical/social information relating to present conditions or situations. All sections are to be completed. If information is unobtainable for some reason, the situation should be noted on the form. On occasion, completion of an item may be deferred. Deferring an entry means that it will be completed later; it does not mean eliminating or not attempting to get the information at all. If completion of an item is deferred, the reason will be noted along with any plans for obtaining the information at a later time."

Corrective Action:

As findings do not represent a trend, a CAP is not required.

III. B. Care Plan

Care planning is the process of developing an agreement between the client and CM regarding identified client problems and resources, outcomes to be achieved and

services to be pursued in support of goal achievement. The care plan must reflect services and supports necessary to sustain the client's ability to live in their community. The care plan provides a focus for the needs identified in the functional assessments, organizes the service delivery system to the client and helps to assure that the service being delivered is appropriate to the client's needs/problem.

The MSSP interdisciplinary care management team will develop a client-centered written comprehensive care plan for each client. It will be based on IHA and IPSA or reassessment findings, reflect all appropriate client needs, encompass both formal and informal services and will be written within two weeks of the latest assessment or reassessment.

The MSSP Care Plan includes:

- Statements of problems and needs determined upon assessment;
- Strategies to address the problems and needs; and
- Measurable goals or outcomes used to demonstrate resolution based upon the problem and need, the time frame, the resources available, and the desires and the motivation of the client and/or family.

References: MSSP Site Manual and MSSP Contract

Findings:

Problem Statements

All client records reviewed, except #XXXX and #XXXX, contained problem statements that either did not describe why the issue was a problem for the client, were not client centered, included interventions, did not relate to the client's functional deficit(s) or did not substantiate the need for the services. Some client records contained verbiage such as "due to financial constraints."

Client Record #XXXX contained problem statements added after the initial care plan was written that were out of numerical sequence.

Goals

All client records reviewed, except #XXXX and #XXXX, contained goals that were not measurable or goals that contained interventions.

Interventions

All client records reviewed, except #XXXX and #XXXX, contained interventions that did not completely address the problem statement. For example, the purchase of an XXXX (XXXX) was the only intervention for a problem statement regarding XXXX. An XXXX does not prevent XXXX.

Other Care Plan Findings

Four client record (#XXXX, #XXXX, #XXXX, and #XXXX) contained client needs identified during assessments that were not included on the care plan. The progress notes did not explain why those needs were not addressed.

Six client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained care plans that were not updated for retired or resolved problem statements as documented in progress notes.

Two client records (#XXXX and #XXXX) did not obtain the client's signature within 30 days of care plan approval.

Client record #XXXX contained a care plan that was not completed within two-weeks of the last reassessment.

Client record #XXXX lacked the CM's signature on the care plan.

Client record #XXXX lacked a service provider listed on the care plan.

The date of the care plan conference was missing from all care plans.

Recommendations:

Incorporate all TA provided during the exit conference and in this report. Conduct a training session within 60 days from the date of this report to ensure CMs follow MSSP Site Manual requirements. Submit to CDA the name of the instructor, materials used, and a sign-in sheet of attendees.

Sixty days following the care plan training, the site will submit to CDA for review, one care plan from each CM along with the associated reassessment summary. The care plans will be reviewed by CDA and additional TA will be provided as necessary.

Technical Assistance:

Problem Statements

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states:

Problem statements must describe areas of concern identified in the re/assessment. They must define the problem and substantiate the need for the service. Problem statements are derived from problem lists, written in complete statements, are client centered and relate to the client's functional status. Problem statements do not include interventions.

For example, client record #XXXX contains the following problem statement written to address the need for a XXXX:

- *"Client's XXXX lacks XXXX XXXX to assist her with XXXX."*

This problem statement does not describe why the lack XXXX XXXXis a problem for the client or why the client needs assistance with XXXX. The statement also includes the intervention, XXXX. An example of a better problem statement to address this need is:

- *The client is at risk for XXXX d/t XXXX secondary to XXX resulting in inability to XXXX.*

As mentioned during the exit conference, item centered problem statements are not recommended. An example of a more global problem statement to address all IADL needs is:

- *Client is unable to perform XXXX and XXXX d/t XXXX secondary to XXXX and XXXX from XXXX.*

Another example of a problem statement from client record #XXXX is:

- "Client is unable to XXXX, XXXX, XXXX or XXXX XXXX."

This statement does not substantiate the need for services because it does not describe the client's functional deficits which would explain why the client needs assistance with IADLs. An example of a correct problem statement for this need is:

- *Client needs assistance with XXXX d/t XXXX secondary to XXXX and XXXX related to XXXX and XXXX.*

Goals

Review MSSP Site Manual Section 3.640 Care Planning which states, the MSSP care plan includes measurable goals or outcomes used to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client/family.

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states, "The goal is the desired end result to be achieved. The goal will specify the skills to be acquired, behaviors to be changed, information to be provided, health or psychosocial conditions to be met. The outcome identifies the anticipated result or benefit to be obtained from the service provided."

Goals must be specific, measurable, attainable and realistic. Goals do not contain interventions.

Client record #XXXX contained the goal:

- *"Maintain XXXX for the client at home with the assistance of XXXX XX out of XXXX per year."*

This goal does not address the problem which is the client is unable to complete their own care needs. This goal also contains an intervention, XXXX. An example of a better goal for this client is:

- *Client will have XXXX on a daily basis as reported during monthly contacts.*

Another example of a goal from the care plan for client record #XXXX is:

- *"The client will have an XXXX in the home to support XXXX XXXX monthly."*

The problem associated with this goal is that the client is XXXX, is at risk for XXXX due to XXXX on XXX XXXX. This goal does not address that need. The goal also contains an intervention, an XXXX.

To address the problem of a client at risk for XXXX, the goal could be:

- *Client will be free from XXXX over the next 12 months.*

The XXXX is an intervention used to access XXXX if needed if a XXXX does occur.

Interventions

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states, "The Plan/Intervention section lists information pertinent to the problem and outlines possible actions, plans or solutions to solve the problem."

- Interventions address the client's needs and relate specifically to accomplishing the goal. Language must imply some action such as "refer," "assist," "arrange," "purchase," "advocate," "obtain" or "monitor."

The health and safety of our clients is of utmost importance. A client at risk for falls has the potential for health decline or hospitalization if a fall occurs. We must do everything in our power to prevent falls. Although an ERS device is an appropriate intervention to address the issue of fall risk, it must not be the only intervention. An ERS device does not prevent falls. It is only helpful once a fall has occurred to access emergency services. Interventions that could be included to address fall risk are:

- Complete a MSSP Fall Risk Assessment tool (Appendix 21g)
- Coordinate with MD re: Referral for OT and PT evaluations and DME prescriptions from recommendations
- Arrange OT and PT services for strength training and gait balance
- Coordinate with DME provider to obtain recommended equipment via Medi-Cal TAR (list specific equipment recommended)
- Monitor monthly for falls and appropriate use of equipment in place
- Encourage client to remove loose/throw rugs from home
- Provide ongoing fall prevention education
- Coordinate ramp installation to ensure easy access into and out of home
- Purchase ERS device to common help in case of falls

Other Care Plan Technical Assistance

Review MSSP Site Manual Section 3.640.1 General Guidelines which states, "The care plan will address all appropriate needs of the client, including general health and welfare issues. Any needs or services deferred must have appropriate justification for the deferral documented in the client record."

Review MSSP Site Manual Section 3.640.8 Changes to the Care Plan which states, "Care plan documents (i.e., the care plan and SPUS) must be updated/revised when warranted by changes in the client's condition, goals or service needs."
The site was notified that the requirement to obtain the client's signature on the care plan is now 90 days.

Review MSSP Site Manual Section 3.640 which states the care plan must be written within two weeks of the latest assessment or reassessment.

Review MSSP Site Manual Section 3.640.4 Care Plan Approval which states, "The PCM will write the care plan based on the assessment findings. Both the PCM and SCM must sign the care plan within two weeks of the last re/assessment. These signatures are required to activate the plan and to initiate purchases with waiver funds."

Review MSSP Site Manual Section 3.640.3 Care Plan Components which states the service provider name will be listed on the care plan for all services, purchased and referred. The type of provider(s) for each service will also be entered, either informal, referred, purchased or care management.

The care plan conference date is a required component on the care plan form. CDA finds it acceptable to enter the care plan conference date on your Checklist for Care Planning and Certification Sessions form rather than the care plan form.

Corrective Action:

As these findings represent a trend, a CAP is required.

III. C Assessing and Documenting Client Risk

The goal of risk assessment is informed by the fact that MSSP clients have the right to refuse specific services and interventions. When a client refuses a service or intervention, the site must have a process of assuring that the risks associated with the refusal are addressed to the extent possible.

Assessing a client's ability to assume risk includes whether or not the client can:

- Make and communicate choices;
- Provide sensible reasons why choices were made;
- Understand the implications of choices; and
- Consider the consequences of choices.

A risk management plan will be developed when a situation arises where the client has chosen a course of action that may place the client at risk. This process allows for the systematic exploration of situations with a high possibility of an adverse outcome.

The status of the risk management plan must be monitored during regular monthly contacts by the CM. It must be formally reviewed or renewed at intervals mutually agreeable to the client and CM.

Reference: MSSP Site Manual
Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

III. D. Progress Notes

Progress notes are the ongoing chronology of the client's events and care management. They must address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client's response to the service. Notes shall include the following, as appropriate:

- The date and type of MSSP staff contact with the client;
- A record of all events that affect the client and the status or validity of the care plan;
- Actions taken when there are discrepancies between the care plan and services delivered;
- Any education or counseling support provided to either the client or caregiver;
- Evaluative subjective and/or objective comments on all services delivered and client outcomes in relation to needed services; and
- A reflection of the relationship between identified problems and services delivered or not delivered.

Progress notes must include any significant information regarding the client's relationship with family, community or any other information which would impact the established goals for the client's independent living.

Reference: MSSP Site Manual

Findings:

Seven client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) lacked progress note documentation that education had been provided to the client.

Five of fifteen client records (#XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained progress notes that did not address each care plan problem statement each month.

Two client records (#XXXX and #XXXX) contained "item" centered documentation in the progress notes.

The XXXX 2009 progress note for client record #XXXX was missing.

The XXXX 2009 progress note was provided during the review for client record #XXXX from hand written notes saved by the CM; however, no client contact was made that month due to XXXX.

Client Record #XXXX lacked progress note documentation that the client had been XXXor XXXX to a XXXX, as documented on the IF.

Client Record #XXXX contained progress note documentation stating the client had received XXXX from XXXX, although no CM referral had yet been made. The client was actually using XXXX. Once this error was discovered, a referral to XXXX was made.

Client Records #XXXX and #XXXX, a XXXX, contained extensive documentation in the XXXX 2009 progress notes regarding the client's XXX XXXX and XXXX XXXX. A referral to XXXX (XXXX) was made. The XXXX 2009 progress notes (out of review period), documented that the client's XXXX was XXXX with no mention of the XXXX XXXX.

Recommendations:

Incorporate all technical assistance provided during the exit conference and in this report. Conduct a training session within 60 days from the date of this report to ensure CMs follow MSSP Site Manual requirements. Submit to CDA the name of the instructor, materials used, and a sign-in sheet of attendees.

Technical Assistance:

Review MSSP Site Manual Section 3.810 General Requirements which states, "Progress notes document all care management activity, and must be updated with an entry at least monthly."

Review MSSP Site Manual Section 3.820 What Progress Notes Include which states, "Progress notes are the ongoing chronology of the client's events and care management. They must address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client's response to the service. Notes shall include the following, as appropriate:

- Progress notes must address and document each problem listed in the CP;
- The date and type of MSSP staff contact with the client (whether the contact was a home visit or telephone call will be specified);
- A record of all events that affect the client and the status or validity of the CP (e.g., hospitalization, collateral contacts with other agencies);
- Any education or counseling provided to the client or caregiver to ensure that the needs of the client are met;
- Actions taken when there are discrepancies between the care plan and services delivered."

The "item" centered progress note documentation is related to the "item" centered care plans. Once training and modifications are made to the care plans, the progress note documentation will reflect the status of the client instead of items or interventions that are in place.

If billing occurs for care management and administration when progress notes are missing or no client contact takes place during a month, there is a possibility of recovery.

Corrective Action:

A CAP is required.

III. E. Case Record

MSSP sites must maintain up-to-date, centralized, confidential and secured case file records for each MSSP client, utilizing mandatory CDA forms. Sites are to implement case documentation, date and signature requirements, revisions and corrections according to the MSSP Site Manual specifications and time frames.

Case record documentation is a tangible part of the care management process which must be clear, timely, accurate, legible, appropriate and complete, providing the CM with working documents that are effective and efficient. The site shall also maintain and make available records for inspection and audit by the State.

Reference: MSSP Site Manual

Findings:

Three client records (#XXXX, #XXXX, and #XXXX) contained changes to the client record made incorrectly.

Recommendations:

Incorporate the following TA into site policies and procedures.
Technical Assistance:

Review MSSP Site Manual Section 5.700 Corrections which states, "The client record is required to be complete, timely, accurate, and legible. Clean corrections keep the client's record accurate and keep staff legally protected. In order to avoid legal problems, use the following methods for changing information in a client's record:

a. Draw one line through any incorrect information, without obscuring it. Write the date and initial..."

Corrective Action:

The findings did not represent a trend; therefore, a CAP is not required.

IV. AUTHORIZATION AND UTILIZATION OF SERVICES

MSSP sites are responsible for maintaining complete records for funds received under the MSSP contract, including the tracking for purchased and referred services. Sites are required to cooperate with the State in the monitoring, assessment and evaluation of site processes. Sites must provide the CDA any relevant information requested through ad hoc reports that are related to administrative procedures.

The Department's Audit Branch will review the reconciliation process between service authorization and disbursement of payments to ascertain whether services authorized and provided were:

- Consistent with the care plan,
- Verified by the site, and
- Differences between authorized and verified services noted.

CDA MSSP staff will review selected client records to verify that correct procedures were followed in authorizing services for clients.

In authorizing services for a client, the CM will use the following prescribed order of priorities:

1. All services available through the informal support of family, friends, etc., must be used.

2. Existing Title XVIII Medicare, Title XIX Medi-Cal, Title XX Social Services, Title III Older Americans Acts, the Special Circumstances Program, and other publicly-funded services for which the client is eligible, and which are available in the community, must be relied upon, coordinated and recorded in developing a care plan. Within MSSP these services are called "Referred" services.

3. Only after the client's informal support and the existing public and private services are reviewed and optimally used, can the CM request the use of MSSP funds to purchase Waived Services. Within MSSP, these services are also called "Purchased" services.

CMs must be aware of the cost associated with maintaining a client in MSSP. When considering the acquisition of a piece of client equipment, e.g., emergency response device or non-medical home equipment, it is important to analyze both the purchase and rental options to determine the most cost-effective approach.

References: MSSP Site Manual and Contract

IV. A. Service Planning and Utilization Summary

The SPUS is an element of the client's care plan. The SPUS sets forth specific service information: who is the provider, what service is provided, how much it will cost, and what is the source of payment.

The SPUS is to be completed for each client for each month they are enrolled in the program. The services tracked on the SPUS are those purchased with waived services funds and certain categories of services obtained by referral to other funding sources.

The primary CM signs each client's verified SPUS each month. If the client's tracked costs are more than 95%, but less than 120%, of the site's benchmark, the Supervising CM must also sign; if costs exceed 120%, the Site Director must sign the SPUS, too.

References: MSSP Site Manual and Contract

Findings:

Record review revealed several findings; however, a pattern of deficiency was not detected.

- One client record (#XXXX) provided payment for an item not on the Care Plan which could be subject to recovery.
- One client record (#XXXX) provided continued purchase of XXXX XXXX (XXXX) without following the required protocols set forth in the MSSP Manual (Section XXXX for Service Code XXXX).
- One client record (#XXXX) was reviewed where item cited on the Care Plan did not match the item on the SPUS.
- There were two records (#XXXX and #XXXX) that did not have the referred services listed on the SPUS.

Recommendations:

Continue with current policies and procedures.

Technical Assistance:

Review MSSP Site Manual Chapter 3, Sections 3.640 – Care Planning; 3.640.1 General Guidelines; 3.640.6 – Care Plan Monitoring; 3.640.8-Changes to the Care Plan; 3.930 –Authorization and Utilization of Services; 3.1430 – Waived Services (Food 7.3).

Corrective Action:

A CAP is not required.

IV. B. Tracking Cost Effectiveness

In addition to care management services provided by the MSSP site staff, the program is authorized to purchase supportive services from the list of approved Waived Services.

MSSP CMs are required to follow service authorization procedures which maximize the use of the informal support system and existing community service delivery systems (including use of the Medi-Cal Treatment Authorization Request [TAR] process) prior to the use of Waived Services.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. C. Vendor Agreement Review

Sites are responsible for arranging for the provision of client services. In addition to the MSSP Site Manual, there are two documents that must be consulted in this regard: the current MSSP Waiver and the individual site contract with CDA. Both the Waiver and the contract set forth policy and procedures which must be followed in structuring the terms and conditions of agreements with local service providers. In the contract, the site agrees to directly provide or arrange for the continuous availability and accessibility of all services identified in each client's care plan. In addition, the site agrees to maintain sufficient written vendor agreements for the following minimum array of Waived Services at all times.

(a) Adult Day Support Center (ADSC) and Adult Day Care (ADC)
(b) Housing Assistance
(c) Domestic Chore and Personal Care Services
(d) Care Management
(e) Respite Care
(f) Transportation
(g) Meal Services
(h) Protective Services
(i) Special Communications

Sites are required to maintain specific information and documents on each vendor of services. Sites must maintain copies of current license and insurance documents, and establish a tickler file or other system to ensure timely updating of this information. The Vendor Record Review Tool can assist sites with maintaining service provider compliance to MSSP requirements.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. QUALITY ASSURANCE ACTIVITIES

Quality assurance (QA) is characterized by a focus on systems, processes and outcomes, rewarding excellence, and working in a collaborative or partnership environment. It is ongoing, with each element continuously informing and supporting the entire process. Rather than replacing traditional program evaluation activities, quality assurance builds on and integrates them into an organized system.

MSSP sites are required to deliver quality services to clients through the continual demonstration of best practices in clinical care management. Sites will have a written policy describing their QA activities that includes a vision/mission statement, which ensures that staff fully support the mission and specifies the elements employed to secure this vision. QA elements include, but are not restricted to, a process of peer/internal review and a means to solicit client satisfaction with MSSP services.

V. A. Peer/Internal Review

Peer/Internal Review activities focus awareness on care management activities practiced within the program. Driven by the needs and abilities of the care management staff, this review process offers CMs an opportunity to learn from each other through the critical examination of professional practices.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. B. Client Satisfaction

Client Satisfaction Surveys, or other methods of obtaining information regarding client satisfaction, are instrumental to program operation analysis and the provision of quality client services.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. C. Home Visit

A home visit to a client ensures that clients are informed of their rights and receive quality services that meet their needs.

References: MSSP Site Manual and MSSP Contract

Summary of Home Visit

On Tuesday, XXXX XXX, XXXX, an SWCM and I visited client #XXXX, a XX year old XXXX who lives alone. The client has a history of XXXX XXXX and cannot XXXX or XXXX. A XXX was recently discovered in XXX XXXX for which XXX had XXXX and was recovering. XXX medical history also includes XXXX, XXXX, and XXXX.

The client was sitting in XXX XXXX XXXX XXXX and wearing her XXXX XXXX XXXX XXXX on XXX XXXX. Yvette talked with XXX, reviewed XXX XXXX XXXX and asked if XXX had any new needs. The client was waiting for XXX XXXX to be XXXX and just as XXX were leaving, the XXXX arrived. The client stated XXX is very happy with

XXXX and the services provided through our program. XXX could not think of anything that would make it better.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

VI. BEST PRACTICES

Best Practices are those processes, policies, procedures and methods of casework that demonstrate exemplary work in the field of care management. Examples of Best Practices include, but are not limited to, administrative processes, the work done within an individual case, and general practices developed and applied to the work of all site care management staff.

The review team would like to acknowledge the site for the following examples of Best Practices:

1. Use of a checklist for care planning and certification sessions shows collaboration between those attending the meeting and ensures all required forms are completed in each record.

VII. SUMMARY

The site is acknowledged for its hospitality and for being receptive to the recommendations made and the TA provided during the UR process. This review team is available to provide continued technical support regarding the findings identified in this report.